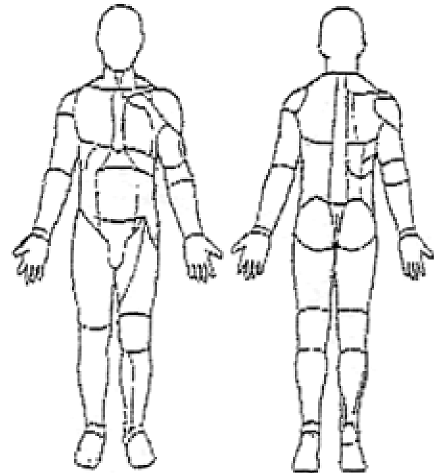
OUTPATIENT DIAGNOSTIC CENTER
PATIENT HISTORY AND SCREENING FORM FOR MRI

Patient Name: _________________________________Date:______________Sex: M F
Weight______
DOB: ___________________
Referring Physician____
Clinical History: Please explain your medical problems that are the reason for having an MRI today:____
____
____
____

Previous X-ray, MRI or CAT Scan: YES [ ] NO [ ] _______________________________

DO YOU HAVE ANY OF THE FOLLOWING ITEMS IN YOUR BODY?

Pacemaker	Yes	No
Ear/Cochlear Implant	Yes	No
Brain/Aneurysm Clips	Yes	No
Metal in eyes or ever Had any removed	Yes	No
Metal fragments or Shrapnel	Yes	No
Implanted electrical device	Yes	No
Neurostimulators	Yes	No
Stents	Yes	No
Sickle Cell Anemia	Yes	No
Dentures held in with magnets	Yes	No
Tattoos/Permanent Make-up Body piercing	Yes	No



Any other metal objects or implants_______________________
List previous Surgeries____

Have you ever had an injection of contrast for an MRI?	Yes	No
If yes, did you experience any of the following?		
Hives	Yes	No
Shortness of breath	Yes	No
Other problems		

Explain____

FEMALE PATIENTS

Is there any possibility of pregnancy	Yes	No
Are you currently breast-feeding	Yes	No

Date of Last Menstrual Cycle __________________

I have answered these questions to the best of my knowledge and understand the information presented to me.
Patient/Parent/Legal Guardian Signature____

Date: ___________________Technologist/Witness Signature_____________________________